Patient Information Form

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_

**Check all that apply:** Male \_\_\_\_ Female \_\_\_\_ Minor \_\_\_\_

Parent/Guardian Name(s) (if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @\_\_\_\_\_\_\_\_\_\_.

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Cardholder’s Name**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Cardholder (if different from patient’s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOU HAVE UNMET DEDUCTIBLE WHAT IS THE REMAINIG AMOUNT**? $\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Insurance Authorization for Assignment of Benefits/ Information

I, the undersigned, authorize payment of medical benefits to the Audiology Center of NJ for services furnished by Dr. Maryam Esmaeli. I also understand that I am financially responsible for any amount not covered by contract. I also, authorize you to release to my insurance company or their agent information concerning healthcare advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating the patient and administering claims of benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature (Parent/Guardian signature if minor) Date

Notice of Privacy Practices

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), the Audiology Center of NJ is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. Audiology Center of NJ collects health information from patients and may store them in paper and digital form (file and computer storage, respectively) under medical records. Medical records are the property of Audiology Center of NJ; however, the information in a patient’s specific medical record belongs to that patient. Following this, Audiology Center of NJ securely holds your medical record(s), and all such personally identifiable information/data will not be disclosed or shared with any third party without a patient’s prior notice and permission; Audiology Center of NJ protects the privacy of your health information. A patient’s records may be disclosed for the following purposes and/or reasons:

Payment**:** We may disclose diagnostic treatment details to your insurance provider in order to obtain payment for services rendered. We may disclose your health information—if required by law—to regular health care operations, judicial and administrative proceedings, law enforcement, deceased person information, specialized government functions, public health services, health oversight activities, notification and communication with family members. Details may also be provided as part of the treatment process—if another treatment provider is treating you, we may discuss your case in order to coordinate care between us. The shared health information may include your diagnosis, hearing test results, etc.

Research:We may anonymously provide data (all personal information removed, unless necessary for dealing with a public health hazard) to government studies, public health activities, and established/approved research (ex: Institutional Review Board-approved research).

Worker’s Compensation: We may disclose any information deemed necessary to comply with worker's compensation laws.

The Audiology Center of NJ may contact you to provide appointment reminders. You have the right to access of your medical records by completing a Request for Patient Access to Health Information Form. Audiology Center of NJ reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment.

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this notice of Privacy Practices. Yes \_\_\_ No \_\_\_ I wish to receive a copy of Notice of Privacy Practices (If not signed by the patient indicate relationship): Parent or guardian if patient is a minor\_\_\_ Guardian or conservator of an incompetent patient\_\_\_ Beneficiary or personal representative of deceased patient\_\_\_

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In a further effort to protect your health information and confidentiality of your healthcare, we ask that you designate below to whom the staff at Audiology Center of Maryland, Inc. may discuss your healthcare & scheduling needs and receive/send a report of diagnostic findings, evaluation, and management progress of this case from/ to the following:

Family Doctor\_\_\_ ENT\_\_\_ School\_\_\_ Speech-Language Pathologist\_\_\_ Other\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply:

Leave a message with detailed information for me at: Home\_\_\_\_ Work\_\_\_\_

OK to leave a message with call-back number only\_\_\_\_

OK to e-mail me at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_.

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_